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Health Care Consumer Choice
The Role of Information

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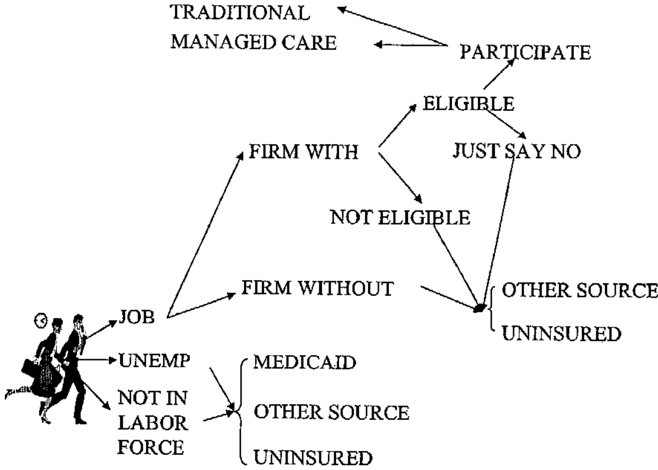
Choice is a highly prized commodity in the United States. The freedom to choose is fiercely protected. Recently health care consumers have felt as though their freedom to choose has been threatened: when they seek care, from whom, and how often; the site of treatment, whether inpatient or outpatient; whether they can spend a third day in the hospital after a normal delivery; whether they can purchase generic rather than brand-name drugs. Rightly or wrongly, they blame a lot of this loss of freedom on the growth of managed care. We are witnessing a plethora of articles and stories in the mainstream press, on television, even in movies like *As Good As It Gets*, as well as testimony at federal and state legislative committee hearings debating Patient Bill of Rights legislation.[1]

What most people may not realize is that before a consumer, a patient, ever reaches an individual health care provider's office to discuss a particular diagnosis and treatment, a myriad of decisions have been made—decisions that influence the selection of the provider, the treatment, and how much the treatment will cost the patient. The typical health care consumer faces a road map of options, and the consequences of taking one option instead of the other are always attached to those choices. In many cases, when consumers make one choice, they are getting on a one-way road with that choice leading to future constraints.

As illustrated in Figure 1, for some adults the first choice that may in part be conditioned on an individual's desire for health insurance coverage is whether to enter the labor market. The role played by Medicaid in the welfare-to-work decision is frequently discussed. Less attention is paid to the effect of health insurance coverage on other

Figure 1 Labor Market and Health Insurance Choices



populations, but the desire for affordable health insurance may also influence the labor market decisions of those not eligible for Medicaid, such as spouses of working adults without employment-based insurance.

Adults who do not seek employment or who are unsuccessful in finding a job end up either covered by Medicaid, obtaining insurance through another source (e.g., a spouse's plan or a plan obtained in the nongroup market), or uninsured.

VARIATION IN FIRM OFFER RATES

The decision of what kind of firm in which to seek employment is also influenced by the demand for health insurance. Health insurance options vary by firm. While health insurance is but one factor in firm choice, it's not difficult to believe that young, single males may deliberately choose to supply their labor to a small, high-tech firm that offers no health insurance in exchange for higher wages. It is also

understandable that a young male who has similar skills but who has a wife and two small children may choose instead to supply his labor to a large corporation, earning a lower salary but receiving a rich family health insurance package at a large group rate.

Approximately 25 percent of working adults are employed by firms that do not offer health insurance (McLaughlin 1999a). Small firms, those with 25 or fewer employees, are disproportionately represented in this group. While 90 percent of firms with 100 or more employees offer some kind of group health insurance package to their workers, less than half of those with fewer than 10 employees do so. These differences in offer rates have been fairly constant over time and stem from a variety of labor and insurance market differences (Brown, Hamilton, and Medoff 1990; McLaughlin and Zellers 1992).

Affordability

A survey of approximately 2,000 small businesses in seven cities revealed that the reasons for not offering a group health insurance policy to their employees could be grouped into three different categories summarized as affordability, employee attitudes, and availability (McLaughlin and Zellers 1994). The number-one reason given in this and other surveys is dollars; virtually all small business owners say that high and rising health insurance premiums are the primary reason for not offering health insurance. The lack of affordable health insurance products is a central problem for small businesses and their employees. Many small businesses operate on low profit margins and face premiums 10–40 percent higher than those paid by large firms (GAO 1992). The convergence of low profit margins, low wages, and high premiums means than neither employers nor employees in small businesses can easily trade revenue or wages for health insurance.

Attitudes

The failure of many small businesses to purchase health insurance has as much to do with attitudes and perceptions as with affordability. The majority of owners who did not offer insurance (61 percent) said that they had no interest in offering any (McLaughlin and Zellers 1994). To some degree, this attitude reflects the nature of the business.

For example, one shrimper in Tampa said, "I go to the dock every morning and say 'You, you, and you, jump on board.' What am I supposed to do? Get them to sign a Blue Cross and Blue Shield contract for the day?"[2] In addition, many small businesses have very loosely defined or temporal employment contracts with their workers (e.g., taxi cab drivers, construction workers).

The driving force behind this lack of interest, however, was the belief that their workers did not want coverage, that they preferred higher wages to health insurance. In contrast to what many workers apparently believe, the employer does not pay for health insurance. Regardless of who writes the premium check, the workers and consumers pay for insurance through lower wage growth and higher prices (Pauly 1997); the owners surveyed felt as though their workers were not willing to make the trade. Many of these employees can piggyback on the (usually better value) health plans of spouses' employers, which appears to be a key reason why many companies do not provide coverage for their employees. Because employees of these other firms rarely pay the full marginal cost of having family coverage (either directly through higher out-of-pocket premiums or indirectly through lower wage growth), employees who have this safety net for coverage often prefer to be compensated in higher wages rather than in benefits. In firms where employers responded that their employees' ability to get insurance elsewhere was a very important reason for not offering insurance, 73 percent of the employees did obtain health insurance from another source (McLaughlin and Zellers 1994).

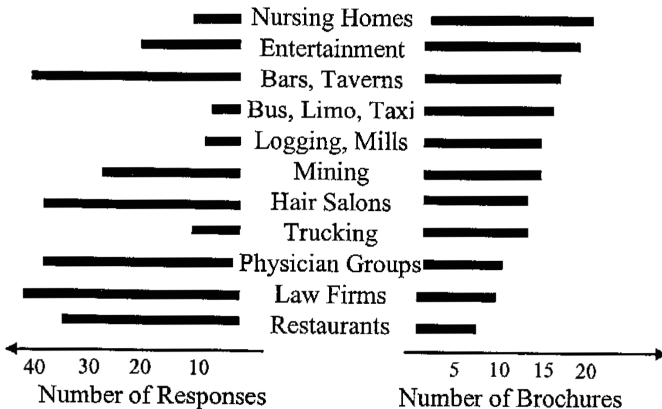
Availability

There was another reason for lack of coverage, however. Some of these owners would have been interested in providing group coverage but expressed difficulty obtaining insurance because of insurance underwriting procedures. For one out of five small businesses without insurance, the lack of insurance can be attributed to redlining and preexisting condition exclusions (redlining is the exclusion of specific types of businesses from eligibility for coverage). Insurers may designate a business unacceptable if they consider employees of these businesses to be at a higher risk for illness or injury because of occupation, age, lifestyles, etc.

Virtually all insurers of small businesses engage in a practice known as redlining, drawing a red line across the list of risks, making all industries with risks above that amount ineligible for insurance (Zellers et al. 1992). McLaughlin and Zellers also surveyed insurance companies and independent agents in the same seven cities participating in the employer survey, as well as the 10 national companies with the largest book of business in the small group market. They asked for examples of industries that are routinely redlined and received underwriting brochures from 20 different companies.

Eighty-five percent of insurance agents and 48 percent of insurance company representatives said they redline specific types of businesses. Seven percent of all small business employees whose companies do not offer insurance are excluded because of redlining practices. As shown in Figure 2, redlined industries are not just those industries such as asbestos removal firms and mining and logging companies that have hazardous working conditions. Major employers such as restaurants, bars, hair salons, physician offices, and law offices are also commonly redlined. About 15 percent of small firms are in industries that are routinely redlined (Zellers et al. 1992).

Figure 2 Types of Redlined Businesses



SOURCE: McLaughlin and Zellers (1994).

Employees in redlined industries are considered "undesirable" not only because of working conditions but because of the age, other demographic characteristics, or lifestyles of employees. Redlined industries typically employ older workers (over age 55) and/or have high employee turnover, seasonal workforces, or workforces paid by commission or on the basis of other contractual terms. The hair salon industry is particularly illustrative of the problem faced by many of the employees of these businesses. As one insurer stated, these employees are seen by insurers as representing a "triple threat: lots of turnover, young women who get pregnant, and gays with the threat of AIDS." Physicians are seen as "heavy utilizers, hypochondriacs," and lawyers as "too litigious, they dispute every claim denied." [3]

While some of these individuals have the financial resources necessary to purchase insurance in the individual market or can obtain group insurance through professional organizations, this is not the case for some workers, such as hair stylists or professional musicians in local symphonies. These individuals decided, most likely in high school, to acquire the human capital necessary to become a professional in this field, not knowing that down the road, when they were no longer "young invincibles" but 30-year-old pregnant women or 40-year-olds with carpal tunnel syndrome or hypertension, they would have problems getting coverage because of their profession. At this point, they either have to change careers, learning new skills marketable to industries that are not redlined, seek individual coverage with a very high premium, or remain without financial protection for any medical care needs. Now, one policy response could be, "Well, you chose this career; you earned a return to that investment, and now you have to face the consequences of that choice." And, as long as that individual had full information about potential problems in the future, an argument can be made that this is an efficient path. In any case, once an individual has acquired specific skills, it is often difficult to move freely in the labor market. Those earlier choices lead to constraints.

VARIATION IN INDIVIDUAL PARTICIPATION RATES

Eligibility

Seventy-five percent of workers are employed by firms that do offer insurance (McLaughlin 1999a). Not all workers are eligible, however; approximately 5 percent of workers are not eligible for their firm's plan.

The most common reasons for being ineligible have to do with the employment contract, particularly working part time (Table 1). Analysis of the 1993 Current Population Survey (CPS) data shows that while 80 percent of full-time workers are offered insurance, only 19 percent of those working fewer than 20 hours a week are. Even this difference is mitigated by the size of firm, with more part-time workers offered health insurance by larger firms. In firms with 100 or more workers, the percentage of at least half-time workers offered health insurance is virtually the same as that of full-time workers. A worker's salary also influences whether or not she or he will be offered health insurance. Higher-paid workers are much more likely to be offered health insurance. Forty-three percent of workers earning less than $7 per hour are offered health insurance by their employers, whereas 93 percent of those earning more than $15 per hour are offered coverage (Cooper and Steinberg-Schone 1997). Once again, this difference narrows as the firm size increases (Bucci and Grant 1995). Younger workers are also less likely to be offered health insurance—only 51 percent of those younger than 25 years old are offered coverage (Cooper and Steinberg-Schone 1997).

Table 1 Reasons for Being Ineligible

- 26% are still in probationary period
- 9% are contract or temporary workers
- 58% are part-time workers
- 2% have preexisting conditions

SOURCE: 1993 Current Population Survey data reported in Yakoboski et al. (1994).

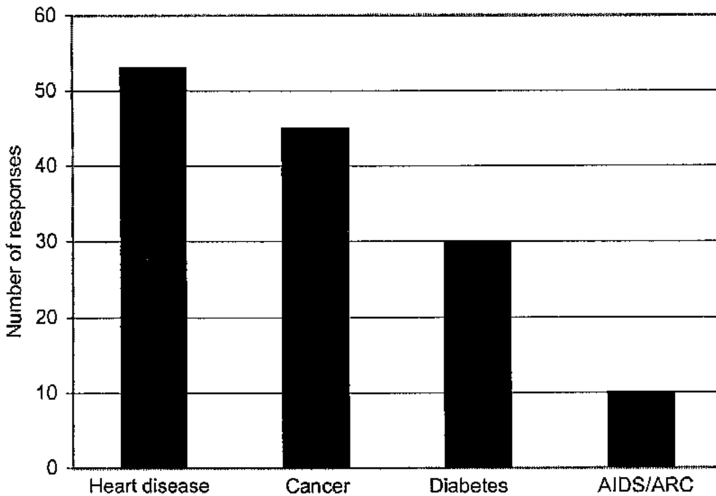
For a small percentage of workers, medical underwriting practices, specifically preexisting condition exclusion clauses, result in ineligibility. Preexisting condition exclusion clauses deny coverage to individuals for conditions for which they have received medical care in the past. With very small groups (fewer than 10 employees), it is not uncommon for an insurer to deny coverage to the entire business if one or more employees has a potentially high-cost preexisting condition.

Again, these barriers are more common in small businesses, not because workers are more likely to have preexisting conditions, but because insurance companies rarely check for these conditions, much less act on them, in large firms. Based on their survey, McLaughlin and Zellers estimated that 15–20 percent of the employees in small firms were ineligible for coverage, not just for the first six months of employment or just for the condition, but for any insurance policy.

Exclusions for preexisting conditions may be a primary reason for "job lock." (Cooper and Monheit 1993). These exclusions discourage workers from switching jobs because they or a family member may not be covered for a health problem under a new insurance plan or may lose coverage altogether. Some of these conditions are chronic conditions and can therefore affect career choices.

McLaughlin and Zellers (1994) found that the most frequently excluded conditions were heart disease, cancer, diabetes, and AIDS (Figure 3). Heart disease was the medical condition that was more commonly excluded for coverage by insurance companies. Fifty-three of the 83 insurance company representatives and agents who were asked about their preexisting condition exclusion policies said they excluded coverage of heart disease for individuals who have already been diagnosed and treated for this condition. Other excluded conditions include mental or nervous conditions, degenerative nerve disorders such as muscular dystrophy and multiple sclerosis, kidney anomalies, and stroke. In some cases, insurers were unwilling to provide coverage for anyone in the firm if one worker had one of these conditions. Interestingly, insurers cited preexisting conditions or "health problems" as the main reason small businesses have difficulty obtaining health coverage.

Figure 3 Medical Conditions Frequently Excluded



SOURCE: McLaughlin and Zellers (1994).

Employee Choice

Some workers who are eligible for coverage choose to "just say no." A recent study comparing household surveys from 1989 and 1996 reveals that a greater number of workers, particularly low-wage workers, are declining to take employer-sponsored insurance (Cooper and Steinberg-Schone 1997). The turn-down rate is higher among low-wage workers. A reasonable interpretation of these data is that these workers are not willing to pay the out-of-pocket premiums and hope to trade at least some wage growth for health insurance. In the 1996 national survey, 80 percent of workers who were offered a plan chose to participate. In contrast, only 63 percent of workers earning less than $7 per hour chose to participate. Less than 50 percent of those working part time chose to participate, in addition to 70 percent of those under age 25 and 74 percent of those working in firms with fewer than 25 employees (Cooper and Steinberg-Schone 1997).

In addition, as noted in Table 2, some workers choose not to participate because they have insurance through another source. Of those

Table 2 Reasons for Choosing not to Participate

- 75% have other source of coverage
- 23% say plan is too costly
- 2% say plan has too many limitations
- 6% say they don't need or want coverage

SOURCE: 1993 Current Population Survey data reported in Yakoboski et al. (1994).

who decline, 75 percent have other group coverage, usually through a spouse's plan (Yakoboski et al. 1994). Analysis of the 1993 CPS data revealed that women were more likely to choose not to participate (Yakoboski et al. 1994). Buchmueller (1996) found that men who work full time are more likely to receive employer-sponsored health insurance than are women who work full time. According to his analysis, this gap is driven largely by the tendency of married women to decline employer-sponsored insurance in favor of being covered through their husband's employer's insurance policy.

The availability of another source of insurance enables many workers to choose employment in the small business community, to say no to costly or undesirable plans, to elect to stay home and engage in child-rearing, or to obtain further training and education. It is also, however, the source of inequities. Employers rarely charge employees, either directly or indirectly, the full marginal cost of choosing a family plan rather than a single plan. Therefore, single workers (or married workers with a spouse covered by employment-based insurance who elect single coverage) subsidize workers who choose family coverage at reduced prices. While society may decide that this subsidy is an efficient way to enable parents to stay home or spouses to remain in school, problems of horizontal inequity arise between similar workers of large firms and small firms.

Not all workers who decline coverage or work for a firm without coverage have insurance through another source; a significant number of them are uninsured. In fact, 85 percent of the uninsured are workers and their dependents (McLaughlin 1999a). The number of medically uninsured adults and children is steadily increasing and is the cause of many policy recommendations, at both the federal and state level.

While some people are uninsured because of underwriting conditions, most are not. Many workers are eligible for coverage yet decline; others work in firms that do not offer coverage. These two groups of workers are very similar in measured characteristics: young, lower wage, and single (Long and Marquis 1993; Cooper and Steinberg-Schone 1997).

In some cases, these uninsured workers feel that they do not need coverage. They are basing this decision on their known health status and past experience. Unfortunately, if one of these workers is in a car accident, or develops cancer or diabetes, we do not say, “Too bad, you made your choice and chose not to trade wages for health insurance. Now we choose not to provide care for you.” In part, we recognize that there is poor information about future needs, about the probability of an exogenous shock to our health status, and we decide to provide care for them that is then subsidized by those who chose to make the trade.

Chernew et al. (1997) estimated the subsidy amount necessary to prompt voluntary participation in health insurance. They estimated that for a significant number of workers, the subsidy would have to be almost as large as the premium; therefore, the welfare loss of mandating that they trade wages for health insurance would be quite high. There is a high price to taking away people’s choice.

CHOICE OF PLANS

Finally, we get to those workers who choose to participate; they remain the majority of working adults. Half of these workers have no choice in plan, and most of them are offered only a traditional fee-for-service plan. Half of those with choice are offered only one or more traditional plans; about one-third are offered only one or more managed care plans. For many workers, the choice of employer determines the choice of plan. Although the percentage of firms offering more than one health care plan is increasing, it is still the case that the majority of all firms offer only one plan (McLaughlin 1999a).

As shown in Table 3, just as being offered any plan varies by firm size, so does the availability of choice of plan types. The percentage of firms offering more than one plan increases with firm size—as low as

Table 3 Combinations of Plan Types Offered by Employers, by Firm Size

	% of firms that offer		% of full-time workers offered	
Combinations of plan types[a]	Firm <100 workers	Firm 100+ workers	Firm <100 workers	Firm 100+ workers
FFS only	74	44	62	32
HMO only	8	8	11	6
PPO only	12	18	14	15
FFS + HMO	3	17	7	22
FFS + PPO	1	2	1	2
HMO + PPO	2	9	3	14
FFS + HMO + PPO	<0.5	3	1	9

SOURCE: Bucci and Grant (1995); BLS data for 1992–1993.
[a] FFS = fee-for-service; HMO = health maintenance organization; PPO = preferred-provider organization.

10 percent of firms with fewer than 100 employees and rising to 90 percent of firms with 5,000 or more employees (McLaughlin 1999a). A 1996 KPMG survey found that only 9 percent of employees of firms with fewer than 10 employees were offered a choice of plans, whereas 54 percent of employees of firms with more than 200 employees were offered choice (Gabel, Ginsburg, and Hunt 1997).

Of those firms that offer a choice, the majority offer a choice between two plans (Bucci and Grant 1995). About one-fifth offer a choice between three plans, and a few offer more than three plans from which to choose. About one-half of all workers with choice are offered two plans, one-fifth are offered three plans, and the rest are offered four or more. Again, the tendency to offer multiple plans increases with firm size. A 1997 Mercer survey estimated that 56 percent of companies with 3,000 or more employees offer three or four plan types (Mercer's Fax Facts 1997).

It turns out that for many of us, the choice of health insurance is an important one. Once enrolled in a particular plan, consumers are constrained by the specifics of the plan. The decisions about when to seek care and which provider to use are influenced by the type and financial

incentives of the plan. The choice of treatment is also constrained by plan specifics. A person who is a risk-taker and who would want every possible treatment known, whether experimental or well-established, if faced with a life-threatening disease, would want a different kind of plan than a person who is more conservative in treatment choice. An employer can use health insurance options to influence the kind of worker seeking employment in that firm. For example, offering a subsidized family coverage benefit may discourage single workers and encourage young workers with families. A firm whose work requires risk-taking may want to offer a high-deductible plan.

LIMITATIONS TO CHOICE

One of the basic principles of managed care is reduced choice, particularly reduced choice of provider. In general, healthier individuals, those who anticipate needing very little interaction with the medical care sector, are going to be less sensitive to this reduced choice. The resulting enrollment of healthier workers, combined with a host of financial incentives and structural aspects, has led to lower premiums. These lower premiums, coupled with low co-pays, particularly for pharmaceuticals, have encouraged consumers to overcome their aversion to reduced choice and elect to enroll in managed care plans when given a choice.

Much of the unhappiness with the managed care market results from lack of information. When surveyed, most enrollees focus on the reduced premia and co-pays and express ignorance about limited choice (Mechanic et al. 1990). When they then get sick and become acutely aware of the limitations, they are unpleasantly surprised and angry (McLaughlin 1999b). Of course, the response can be, "Well, you chose lower costs over limited choice. Now you must live with the consequences." Again, this is assuming that they were fully informed about the consequences of their choice, that they were able to read and understand the fine print in their insurance contract. If workers receive more information, some may choose the traditional plan instead. For the one-third of workers who had no choice other than managed care, the only option is to seek employment in another firm.

In some important ways, the individual who chooses to self-insure faces the least constraints; he or she is free to choose any willing provider. Of course, lack of money greatly reduces this freedom for many. In fact, one could say that for most people, the major constraint to choice is money.

At this point, it is clear that these decisions at the endpoint work back through the other decisions. The perceived need for freedom of choice of provider and treatment may reflect knowledge of medical need, which in turn influences the desire to enter the workforce to begin with. The decision process is certainly not a nice, neat linear model of consumer choice. Rather, it is more like the highways around Los Angeles, looping under and over, with complex figure eights, and equally congested and frustrating to the analyst. Unfortunately, private and public policymakers considering policies that address issues of health insurance choice must look at all the various pieces, recognizing that a change in the relative prices or options faced at one dyad will affect other choices. Only when researchers provide better estimates of the likely size of these so-called unintended consequences will policymakers be able to develop policies that yield the desired effects.

Notes

1. See, for example, *Journal of Health Politics, Policy and Law* 24:5. Special Issue: The Managed Care Backlash, Mark A. Peterson (ed.), 1999.
2. From author interviews.
3. From author interviews.

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